SUPPORTED HOUSING PROGRAMS

INTAKE ASSESSMENT

() Homeless Programs ( ) Non-Homeless Programs

Date of Assessment: **Referral #**
Name: **Meets SPMI Criteria ?**
Address: **SPOE Eligible?**
Telephone: **Diagnosis:**
Date of Birth: **Sex:**
Age: **Veteran?**
SS# **Race/Ethnicity**
Religious Affiliation: **Marital Status:**
Education Completed: **Children's Ages:**
Emergency Contact: **Visitation Rights?**
Relationship: **Telephone:** **Address:**

HISTORY OF HOMELESSNESS

(Include reasons for loss of housing and attach documentation from shelter and/or courts supporting homeless status)

HISTORY OF INDEPENDENT LIVING & CURRENT LIVING SITUATION

(Assess ability to manage a household, pay rent and utilities, reasons for any address changes)

WHAT ARE YOUR STRENGTHS AND SUPPORTS THAT WILL HELP YOU TO LIVE INDEPENDENTLY?

SHP Intake Screening

SOURCES OF INCOME

( )	SSD	ID#	Amount _____	Payee? ____
( )	SSI	ID#	Amount _____	Payee? ____
( )	Public Assistance	ID#	Amount _____	
( )	Employment	Employer	Amount _____	
( )	Savings	Acct. #	Amount _____	
( )	NYS Disability	ID#	Amount _____	
( )	Unemployment		Amount _____	
( )	Pension	ID#	Amount _____	
( )	Family Support		Amount _____	
( )	Other		Amount _____	

HEALTH INSURANCE

( )	Medicaid	ID# _____
( )	Medicare	ID# _____
( )	Private	ID# _____
( )	Other	ID# _____

PCMP II-A/Gold Choice Enrolled?

VOCATIONAL - EDUCATIONAL - REHABILITATION INFORMATION

History of Participation in Vocational Educational Services

Current Program
Institution/Agency:
Contact:
Telephone:
Schedule:

History of Employment:

Current Employer: **Address:** **Job:**

Personal Goals, Aspirations, Interests & Hobbies - What things are you unhappy/dissatisfied with and want to change.?

MENTAL HEALTH & MEDICAL SERVICES

Counseling/Treatment Services	Agency: Address: Counselor/Therapist: Telephone: Appointments:
Prescribing Psychiatrist	Agency: Address: Psychiatrist: Telephone: Appointments:
Case Management/Care Coordination	Agency: Address: Manager/Coordinator: Telephone: Frequency of Contacts:
Medical Services	Physician: Address: Telephone: Hospital Affiliation:

List chronic medical conditions, recommended course of treatment and physician if different from above.

CURRENT MEDICATIONS

NAME	DOSAGE	FREQUENCY
Ability To Self Medicate & History of Compliance:		

PSYCHIATRIC HOSPITALIZATIONS

INSTITUTION	DATES/LENGTH OF STAY	REASON FOR ADMISSION

MEDICAL HOSPITALIZATIONS

INSTITUTION	DATES/LENGTH OF STAY	REASON FOR ADMISSION

RISK ASSESSMENT

History of Substance Abuse & Treatment

Drug(s) of Choice:

( ) Cocaine	( ) Heroin/Opiates	( ) Marijuanna
( ) Crack	( ) Alcohol	( ) Prescription Drugs
( ) IV Drugs	( ) Benzodiazapines	( ) Over the Counter Drugs/Inhalents
( ) Sedatives	( ) Amphetamines	( ) PCP
( ) Other		

How many times did you use in the past week, past month?

Drug & Alcohol Rehab Admissions

INSTITUTION	DATES/LENGTH OF STAY	COMPLETED Y/N

Current Groups, Self-Help and Other Supports

_____
_____
_____

Desired Supports

_____
_____
_____

SHP Intake Screening

History of Suicide Attempts, Gestures and/or Ideations

(Have you ever tried to hurt yourself? When? Where? How? What were the circumstances?)

Prodromal Symptoms & Signs of Decompensation

(How do you know your are getting sick? Is there a pattern related to life events?)

History of Aggressive or Serious Assaultive Behaviors

(Have you ever tried to hurt someone else? Have you ever damaged or destroyed property? When, Where, How Circumstances)

What do you do to control your anger?

History of Sex Offenses/Assaults

History of Arson, Substantiated or Suspected

History of Involvement with Law Enforcement/Judicial System

( ) Supported Housing Occupancy Agreement Reviewed

Comments/Reactions:

CIRCLE OF SUPPORT

Who are the people in you life you can count of for support and help in achieving your goals, dreams and aspirations?

Are there other people you would like included in your support network not currently involved?

May we contact any of the people in your support network regarding your enrollment and services provided?

May we mail surveys regarding our services to any of the people in your support network?

What do you think are your roadblocks/barriers to successful independent living?

How do you think agency staff and people you consider your supports can assist you in overcoming these roadblocks and help you achieve you goals, dreams and aspirations?

Admission Recommendation

( ) Admit ( ) Deny

Denial Reason (s):

Admit with the Following Supports/Resources in Place:

Program Director: _____ Date: _____

Associate Director: _____ Date: _____
(Required for Denials)

Supported Housing Occupancy Agreement

I agree to the following conditions:

To pay my share of my rent on time.

To apply for a Section 8 Housing voucher.

To pay my utility bills.

To verify my funding with staff on an as needed basis.

To access all entitlements for which I am eligible.

To keep my apartment neat and clean, and to keep noise at a level acceptable to the landlord and neighbors.

To meet with my Care Coordinator as scheduled.

To follow through with my clinical treatment.

To meet with my Supported Housing Case Manager as agreed upon in my housing support plan.

I agree that if family or friends will be in my apartment during meetings with my Supported Housing Case Manager, I will discuss this with him/her in advance.

To work on my goals as stated in my housing support plan.

I also agree not have any weapons in my apartment, not possess or use any illegal drugs or allow anyone else to possess or use illegal drugs in my apartment.

If the conditions of this agreement are violated, I understand that appropriate actions may be taken, to include reconsideration of my participation in the Supported Housing Program.

_____	_____	_____
Applicant Printed Name	Applicant Signature	Date
_____	_____	_____
Staff Printed Name	Staff Signature	Date